

Psychoeducation: A Basic Psychotherapeutic Intervention for Patients With Schizophrenia and Their Families

Josef Bäuml¹, Teresa Froböse, Sibylle Kraemer,
Michael Rentrop, and Gabriele Pitschel-Walz

Hospital of Psychiatry and Psychotherapy, Technical University
of Munich, Ismaninger Strasse 22, D-81675 Munich, Germany

Psychoeducation was originally conceived as a composite of numerous therapeutic elements within a complex family therapy intervention. Patients and their relatives were, by means of preliminary briefing concerning the illness, supposed to develop a fundamental understanding of the therapy and further be convinced to commit to more long-term involvement. Since the mid 1980s, psychoeducation in German-speaking countries has evolved into an independent therapeutic program with a focus on the didactically skillful communication of key information within the framework of a cognitive-behavioral approach. Through this, patients and their relatives should be empowered to understand and accept the illness and cope with it in a successful manner. Achievement of this basic-level competency is considered to constitute an “obligatory-exercise” program upon which additional “voluntary-exercise” programs such as individual behavioral therapy, self-assertiveness training, problem-solving training, communication training, and further family therapy interventions can be built. Psychoeducation looks to combine the factor of empowerment of the affected with scientifically founded treatment expertise in as efficient a manner as possible. A randomized multicenter study based in Munich showed that within a 2-year period such a program was related to a significant reduction in rehospitalization rates from 58% to 41% and also a shortening of intermittent days spent in hospital from 78 to 39 days. Psychoeducation, in the form of an obligatory-exercise program, should be made available to all patients suffering from a schizophrenic disorder and their families.

Key words: psychoeducation/schizophrenia/
psychotherapy/relatives/relapse prevention

¹To whom correspondence should be addressed; tel: +49-89-4140-5805/-4210, fax: +49-89-4140-4245, e-mail: j.bauml@lrz.tum.de.

Introduction

According to the guidelines of the American Psychiatric Association (APA)¹ and the DGPPN (German Society for Psychiatry, Psychotherapy and Neurology),² psychoeducational interventions belong to a standard therapy program in acute and postacute phases of patients with schizophrenia.³ In the Cochrane analysis of Pekkala et al,⁴ such interventions were accompanied by a higher level of compliance, lower rate of relapse, and improved psychopathological status. In the context of the currently internationally recognized vulnerability-stress-coping model, with its assumption of a biopsychosocial cluster of causes,^{5–7} psychoeducational interventions as an “obligatory-exercise” program provide the foundation for numerous further treatment measures.

The supreme goal of all therapeutic interventions lies in the boosting of empowerment of the afflicted and their families.⁸ In order that the patients are able to tackle their illness in as optimal a way as possible, they must rapidly develop a basic comprehension of the background of schizophrenia and the treatment options which are currently available. Without the establishment of a differential understanding of the illness and resulting insight, compliance and improvement in coping, long-term and successful cooperation with professional auxiliary systems is doomed to remain suboptimal. It is only from an informed position that the afflicted are able, with support from the 3 integral professional branches of treatment, to fully unfold their self-help potential: pharmacotherapeutic measures to reduce the neurofunctional filter deficit within the limbic system, resulting information processing disorders and subsequent psychotic symptoms; psychotherapeutic measures to extend the repertoire of coping strategies available to the patients and their relatives; and psychosocial measures to reduce general stressors and build up supportive auxiliary systems in order to compensate for illness-induced reductions in stress resilience.^{9,10}

The formulation of a functional concept of illness and the construction of a positive therapeutic alliance are, in the beginning, reserved for one-to-one contacts. The careful introduction of the diagnosis “schizophrenia” and the empathic processing of accompanying feelings

of offense and insecurity can initially only take place in the context of cautiously lead, confidential dialog.¹¹

In the case of schizophrenic disorders, there are, however, a large number of individual facts which, despite individual differences, are generalizable and applicable to the majority of patients.¹² On account of this, it is imperative for the sake of economy that such fundamental information is passed on as quickly as possible within groups. This simultaneously initiates the group dynamic-based potential influence of solidarity and a shared fate, which cannot be achieved within the framework of one-to-one contacts.^{13,14}

Psychoeducational groups also carry the claim of bringing this group dynamic effect to bear in the case of acute and postacute schizophrenic patients. It is therefore the view of the authors that psychoeducation signifies a “specific basic psychotherapy” for acute and postacute schizophrenic patients, which capacitates their self-competent, well-informed, structured, and successful involvement in the modern therapeutic options which are on offer. For this reason, psychoeducation is conceived as a tool for an optimal combination of the self-help potential of the afflicted and their relatives on the one hand and instances of professional help on the other hand.^{15,16} In the following, a more detailed elucidation of why psychoeducation constitutes a specific form of psychotherapy for schizophrenic patients will be presented.

Paralyzing of Empowerment in First Episode Schizophrenia

Most individuals have many natural coping mechanisms at their disposal when dealing with the various demands of everyday life.¹⁵ In the case of first episodes of a severe depression or anxiety disorder, prior experiences of depressive-anxious moods are completely exceeded and most patients, together with their relatives, are not able to use their existing behavioral repertoires in order to counterbalance the suddenly occurring lack of energy, interest, and diminished affect.

Because, however, general depressive feelings and fear are never completely new, a certain level of coping is mostly possible in severe cases of depression, at least in initial stages.

First episodes of schizophrenic disorders, however, represent a fully new and incomprehensible experience. The emerging symptoms, including hearing voices, tactile hallucinations, delusional perception, thought insertion, disorganized thinking, etc., are all completely unfamiliar. Accordingly, most patients and relatives react with helplessness and in an uncoordinated manner. The symptoms which are specific to a schizophrenic disorder are generally so strange and so obscure to the normal citizen that even the individual who has previously proved successful and thrived in life inevitably develops the feeling that they just cannot believe what is happening.¹⁷

Table 1. Psychoeducation—Effective Therapeutic Factors From Supportive Therapy (ST) and Cognitive Behavioral Therapy (CBT)

Therapeutic Dimensions	ST	CBT
Therapeutic interaction (relationship level)	XXX	XXX
Clarification (causal attribution)	XX	X
Enhancement of coping competence (control attribution)	X	XX

In order that patients and their relatives are empowered from an early stage onwards in assuming the most constructive role possible in managing the illness, a “basic competency” with regards to comprehension and handling of schizophrenia is indispensable. To this end, psychoeducation entails teaching those affected the “ABC” of schizophrenic disorders and their treatment.

Preliminary briefing must, in every case, be carried out by a cautious and empathic therapist, in order on the one hand to counteract dysfunctional processes of causal and control attribution and on the other hand to professionally intercept the inevitable feelings of uncertainty and impending demoralization which accompany the communication of specific information concerning schizophrenic psychoses.¹⁸

Brochures, books, and videos can be introduced in a supportive function when it comes to deepening and consolidating verbally transmitted contents. The employment of various forms of media can, however, never be misunderstood as substituting continual dialogical support and supervision, at least during the first episode of psychotic manifestation.

In the following, reasons for viewing psychoeducation as an independent psychotherapeutic approach for acute and postacute schizophrenic patients will be presented. Furthermore, explanations will be offered as to why supportive therapy and cognitive behavioral therapy represent 2 successively supplementary therapeutic elements, which, in combination with humanistic therapeutic measures, constitute the current typical profile of psychoeducation.¹⁴

Core Elements of Psychotherapy

In their analysis of psychotherapeutic methods, Grawe *et al.*¹⁹ isolated 3 pervasive effective factors proving to be integral elements of a successful psychotherapy, regardless of, or rather spanning across psychotherapeutic schools²⁰ (see table 1).

During the clarification phase, fundamental background information surrounding the disorder as well as its impact on the patient’s behavior must be successfully conveyed. From a psychological perspective, the factor “causal attribution” is at this point of relevance. Concerning the enhancement of coping competence, the acquisition of treatment knowledge and practical knowledge

are of foremost importance. Here, psychotherapeutic activity must, in the form of “control attribution,” look to provide tangible assistance when it comes to handling problems which arise.²¹ The third effective ingredient comprises a successful “process of interaction” between the therapist and patient; group interactions in the sense of a “shared fate” also constitute a component of this process.

These 3 fundamental dimensions of psychotherapeutic work represent the basis of psychoeducation. The quality of patient-therapist relationship when interacting with acute and postacute schizophrenic individuals is seen to be of primary importance. It is only when a bridge can be built to reach these patients, for the most part characterized through their illness by extreme mistrust and an attitude of skepticism in view of interpersonal relationships, that the other variables—clarification and enhancement of coping competence—can come to bear. Here, and especially within the initial development of a therapeutic relationship, supportive elements play a central role, whereas behavioral therapeutic techniques dominate in the domain of coping competence enhancement (see table 1).

Psychoeducation

The term “psychoeducation” was first employed by Anderson et al²² and was used to describe a behavioral therapeutic concept consisting of 4 elements; briefing the patients about their illness, problem solving training, communication training, and self-assertiveness training, whereby relatives were also included.

Within the Anglo-American realm, psychoeducation fulfilled less the function of an independent, self-contained therapeutic method and was viewed more as a combination of several therapeutic elements contained within a complex psychosocial intervention.^{23–28}

A multitude of studies have demonstrated clear superiority of psychoeducational family interventions as compared with standard treatments.^{29–33}

In light of the evident decline in duration of stay in medical institutions of patients with schizophrenia since approximately 1980 and the simultaneous necessity for an economic use of therapeutic resources, the demand for compact and yet efficient treatment methods grew. Within this context, from the mid 1980s onwards, an independent understanding of psychoeducation began to unfold in the German-speaking realm. The underlying aim was to create a well-defined, manualized, and curriculum-orientated therapeutic method, adapted to fit the needs of neurocognitively impaired patients with schizophrenia. The working group “Psychoeducation of patients with schizophrenia³⁴” has formulated the following definition:

The term psychoeducation comprises systemic, didactic-psychotherapeutic interventions, which are adequate for informing patients and their relatives about the illness

and its treatment, facilitating both an understanding and personally responsible handling of the illness and supporting those afflicted in coping with the disorder.

The roots of psychoeducation are to be found in behavioral therapy, although current conceptions also include elements of client-centered therapy in various degrees.

Within the framework of psychotherapy, psychoeducation refers to the components of treatment where active communication of information, exchange of information among those afflicted, and treatment of general aspects of the illness are prominent.³⁴

Indications for participating in such a psychoeducational group are wide ranging. There are only few mandatory contraindications, including massive formal thought disorders, manic elevated mood, hearing imperative voices, or acute suicidality with generally reduced stress resilience. Patients can be integrated within the treatment as soon as they are capable of taking part in a group for a period of 60 min. Ideally, only patients suffering from schizophrenic psychoses should participate in the group, in order not to evoke unnecessary confusion in other patients through the schizophrenia-specific informational content.

Group sittings last approximately 1 hour, take place once to twice a week, and consist of between 4 and 16 sessions. Group leaders are in most cases doctors or psychologists; coleaders can be recruited from all relevant and complementary occupational groups.

The superordinate goal can be seen in patients and their relatives acquiring basic competency in order that they may reach well-informed and self-competent decisions as to which of the modern therapeutic options—medicamentous, psychotherapeutic, and psychosocial—are recommendable and suitable in their own case.

As presented in table 2, the formulation of an efficient crisis management plan directed at suicide prevention is of particular importance. Depressive thoughts of resignation culminating in suicidal consideration are to be broached as a sign of postpsychotic depression and on no account made taboo. Additional administration of mood stabilizers, antidepressants, and tranquilizers together with the parallel involvement of the social environment are displayed as being normal. Rapid taking of preprescribed emergency medication in the case of early warning signs and equipping of the individual with crisis telephone numbers and points of contact for intervention constitute components of crisis management programs. In the context of a 2-year follow-up of the Munich PIP study (Psychosis Information Project, 35), no differences were found between an intervention and a control group with regards to suicidal thoughts and actions. It is the view of the authors that—“state of the art”—psychoeducation does not provoke suicidal ideas reported in an outpatient study.³⁵

The psychoeducational procedure described above was assessed within the framework of a multicenter study in

Table 2. Goals of Psychoeducation

Ensuring patients' and their relatives' attainment of "basic competence"
Facilitating an informed and self-responsible handling of the illness
Deepening the patients' role as an "expert"
"Cotherapists"—strengthening the role of relatives
Optimal combination of professional therapeutic methods and empowerment
Improving insight into illness and improvement of compliance
Promoting relapse prevention
Engaging in crisis management and suicide prevention
Supporting healthy components
Economizing informational and educational activities

the German-speaking realm.³⁶ A total of 236 patients suffering from a psychosis from the group of schizophrenic disorders (DSM IV-R/ICD-9) and their relatives were included in the study; 125 patients took part in psychoeducational intervention groups and 111 patients together with their relatives were assigned to the control group. Assignment was carried out randomly. Patients and relatives each received 8 independent psychoeducational group sessions starting during the stay of the patient in a medical institution. Rehospitalization rates (see figure 1) and days in hospital (see figure 2) after 2 years were significantly reduced in the intervention group. It was thus possible to show that a short-term psychoeducational intervention including patients and their closest relatives can have a significant effect on rehospitalization rates and the number of days spent in hospital.

Patients with between 2 and 5 previous hospitalizations showed most profit within a follow-up period of 2 years.

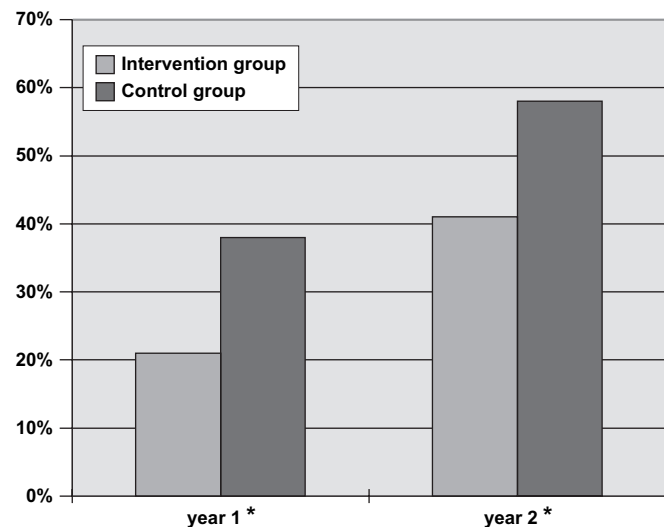


Fig. 1. PIP Study: Rehospitalization Rates in Percent After 1 Year ($n = 163$) and 2 Years ($n = 153$), * $P < .05$.

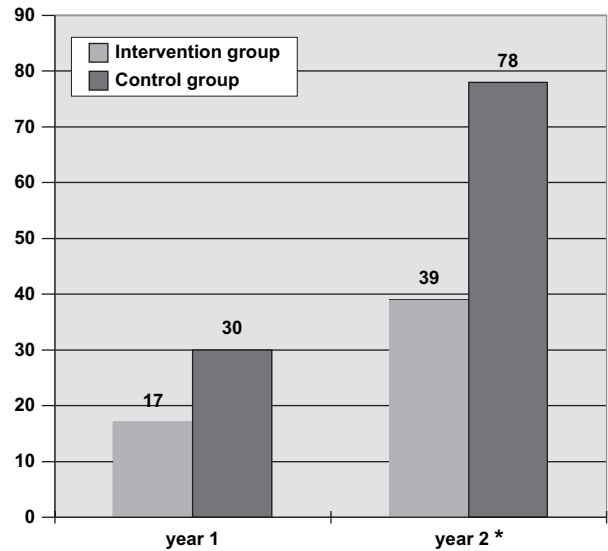


Fig. 2. PIP Study: Days in Hospital After 1 Year ($n = 163$) and 2 Years ($n = 153$). *Mean 39 (SD 90.4) vs mean 78 (SD 127.2), $P < .05$.

Their rehospitalization rates amounted to 34% in the intervention group and 65% in the control group ($P < .005$). Patients who had formerly been hospitalized more than 5 times did not show any difference. This does not, however, constitute an argument against psychoeducation among patients with repetitive exacerbations in general. For patients with a chronic schizophrenic disorder, it is evident that additional long-term psychosocial measurements must be organized in addition to the 8 bifocal sessions.

Nonspecific Effective Factors of Psychoeducation: Supportive Elements With Principles of Encounter Groups

Cautiously supportive accompaniment and supervision of the patient is above all necessary in the run up to first episodes of a schizophrenic psychosis, though also in the case of each renewed exacerbation. By means of an empathic and stoically enduring therapeutic approach, the attempt must be made to build up a stable and sustainable therapeutic relationship, despite alternating ambivalence on the part of the patient (table 3).¹⁴ Within such an approach, there are no clear, down to the very last detail, standardized procedures; even though much the same psychological principles are valid in interacting with schizophrenic individuals as with nonpsychotic patients, it is important to bear in mind that unexpected and initially illogical appearing reactions can occur in light of the patient's psychotically altered perception of the surrounding environment. Under the paradigm of "double-entry book-keeping," it is, however, possible for the majority of those afflicted, despite neither feeling ill nor really possessing insight into the illness, to accept

Table 3. Nonspecific Effective Factors of Psychoeducation

Development of a good therapeutic relationship
Unconditional appreciation
Empathic response to participants
Respectful attention to subjectively deviant opinions
Need- and resource-orientated procedures
Stimulation of hope and reassurance
Encouragement of personal exchange of experiences
Facilitation of “shared fate”

and engage in the therapeutic offer of professional auxiliaries, insofar as these auxiliaries can communicate appreciation, respect, a sense of calculability, and unfailing optimism.

Only when a certain level of trust is established, are patients with schizophrenia prepared to be integrated into a group aiming to form a functional concept of the illness. After all, psychoeducation is of course a voluntary act requiring patients to partake of their own free will. Nevertheless, the commitment and expertise of professional auxiliaries are crucial in motivating patients and their relatives to voluntarily cooperate.

Specific Effective Factors of Psychoeducation: Key Information and Emotional Topics

In accordance with the psychotherapeutic effective ingredients of Grawe et al,¹⁹ the domains’ therapeutic alliance, causal and control attributions are also of utmost importance within psychoeducation. While therapeutic alliance embodies a rather more nonspecific, supportive psychiatric-psychotherapeutic quality, behavioral therapeutic approaches to transmitting key information possess specific psychoeducational effective qualities; this key information comprises facts relating to the illness and its treatment (table 4).

Moreover, emotional, illness-related topics are deliberately discussed. In addition to emotions with a positive

Table 4. Key Information Relating to the Illness and Treatment Measures

Term “schizophrenia”
Symptoms (positive and negative symptoms)
Origin of symptoms: dopamine excess with disturbance in information processing
Vulnerability-stress-coping model
Medication and side effects
Psychotherapeutic interventions and suicide prevention
Psychosocial measures
Early warning signs, crisis plan, and relapse prevention

Table 5. Topics With a Positive Overtone

Feeling of being ingenious and special
Sensitivity as a sign of particular individuality
Pride in own role as an “expert” of psychosis
Expansion of coping competency through psychoeducation
Psychosis as an object of fascination
Acceptance of “being as I am”
Looking for meaning by coping with illness
Solidarity of group with “shared fate”
Support from social network

overtone, such as pride in one’s own role as an expert or the feeling of being particularly individual and original (table 5), more negatively emotional topics, such as being out of one’s depth or struggling with one’s fate, are also addressed (table 6).

Procedures which refresh affective states are of course to be strictly avoided. Through the employment of techniques such as “positivation” of prior experiences, normalization of relapses, or systematic depathologization of individual, failed coping strategies, participants are to be sent the signal that, given close cooperation, a viable solution can be found for all difficulties.

Psychotherapeutic Techniques Within Psychoeducation

The primary goal of psychoeducational interventions consists in finding a common denominator between the objective, textbook medical knowledge with regards to background information of the disorder and treatment measures, and the subjective viewpoint of the afflicted individual. Carrying out this procedure, which often resembles trying to square a circle, requires an extremely differentiated behavioral therapeutic approach, supported by a basic humanistic orientation. For all the psychotherapeutic individuality that exists, 3 clusters of specific effective factors, found in table 7, can be defined analogously to the classification of Grawe et al.¹⁹

Each session comprises a curriculum-based module which is highly structured, whose informational contents are to be interactively compiled; patients are to gain

Table 6. Topics With a Negative Overtone

Insecurity
Being out of one’s depth
Alleged rareness and singleness of own fate
Anger and grief
Resignation
Struggling with own fate
Isolation

Table 7. Important Psychotherapeutic Elements Within Psychoeducation

Therapeutic Interaction
Medical textbook-based general standpoint of therapist as orientation guide
Simultaneous respect and esteem for subjective individual opinions of afflicted
Modeling and imitation of therapists
Modeling and imitation of patients who are successful in handling their illness
Experience of solidarity in group of patients with shared fate
Exchanging experiences with others
Clarification
Conveyance of basic competence regarding knowledge of schizophrenia
Professional simplification of complex facts
Interpretation of complicated scientific information
Visualization of key information
Interactive style of providing information
Presentation of “missing links”
Induction of insight into illness and its requisite treatment measures
Structure and organization into individual therapeutic measures
Two-way conveyance of information
Transmission of understanding and experiences of “enlightenment”
Enhancement of Coping Competence
Focus on resources and not on deficits
Optimized utilization of psychopharmaca
Optimized crisis management behavior
Adequate processing of grief
Modification of life plan
Transformation of patients into “experts” of their illness (knowledge is power)
Enabling relatives to develop into “cotherapists”
Strengthening the protective potential of the family

access to information concerning appropriate mental health behavior.³⁷ Beginning with the individualized experienced-based knowledge of the participants, a common denominator with basic textbook medical knowledge of schizophrenic disorders and their treatment is developed. While individual opinions are appreciated and respected, great value is placed on clearly and comprehensibly presenting current scientifically founded expert knowledge in the form of direct information and advice giving.³⁸ It is less the absolute comprehensiveness of transmitted textbook knowledge which is important and more the construction of a comprehensible concept of the illness and its treatment (causal and control attribution²¹). In particular, the concrete elaboration of “missing links,” which enables lay persons to more fully understand why mental problems can be successfully treated by “chemical” interventions, is of great significance for increasing functionality.¹⁴ In this capacity, psychoeducation can be seen to serve an “interpreter” function, pursuing the aim of translating complicated “technical jargon” into common and everyday language,

which can be understood by patients and their relatives and helps them to become experts of their illness.^{39,40} The leitmotif of all attempts to educate and illuminate must be evident in the fact that patients quasi clumsily progress to a higher stage with treatment of each informational unit and further leave each session feeling encouraged and full of hope. This procedure should not be misunderstood as a minimization or euphemism of schizophrenic disorders. The cautious introduction of the topic of handicaps caused by the illness, which are often severely protracted and unpredictable in terms of duration, also entails a great challenge for simultaneously working on feelings of grief with the patient. Patients and their relatives are to increasingly gain access to positive thoughts and positive conceptualizations of themselves.³⁷ Despite endeavors to remain honest and therapeutically authentic, it clearly cannot be the goal of psychoeducation to confront patients with a merciless picture of all possible negative aspects of the disorder from which they suffer. Psychoeducation is primarily a form of therapy conveying reassurance and hope, with the aim of optimally integrating empowerment of those affected with professional therapeutic techniques in a working and therapeutic alliance.^{41,42}

The take-home-message of psychoeducational programs must be as follows: schizophrenic psychoses are induced by biological factors in combination with psychosocial stress; therefore, they must be treated with both medication and psychotherapeutic interventions. Empowerment of patients can only be successfully developed on the basis of sufficient medication and long-term elements of psychosocial treatment.¹⁸

Realistic Therapeutic Goals in Psychoeducation

The formulation of realistic and coherent therapeutic goals is of particular importance for all involved, patients, relatives, and professional auxiliaries.³ Here, the greatest danger within psychoeducation is that despite the narrow time frame in which the intervention is to be carried out, goals are set which are too high and indeed unattainable.

The very strength of psychoeducation lies in the deliberate focus upon patients and their relatives attaining basic competence in the area of schizophrenic psychoses. In light of the feelings of helplessness and overload with which many patients and their families are confronted, especially at the onset of the illness, this particular element is in no way of secondary importance. On the contrary, it is only when a basic understanding of the illness and its requisite therapeutic measures have been established that more continual and specific therapeutic elements can be employed. Consequently, as helpful as the definition of additional therapeutic elements of Anderson *et al.*²² may be, and as automatic as it is incorporated into everyday interaction with patients, the prior

development of a certain level of fundamental competence in the area of psychoses is essential in the case of first episodes or at the onset of a reexacerbation.

It would not only be unrealistic, but also be, for many patients in an acute or postacute phase, a complete overexertion if too many elements of communication training, problem solving, training of social competence, etc. were to be integrated into short-term psychoeducational programs. Significant improvements within these additional listed areas are only possible within the framework of more intensive and long-term psychotherapy.^{10,43,44} This presupposes, however, a certain level of resilience and capacity on the part of the patient. In the case of family therapy, further logistical preconditions must also be fulfilled before therapy over a longer period of time is possible.

Like it or not, these preconditions lead to the exclusion of those patients who are particularly severely ill.⁴⁵ Yet, psychoeducation pursues the very opposite goal and is indeed designed to be easily accessible for all patients. Psychoeducation should ensure a comprehensive introduction into the realm of psychoses for patients with a first episode of schizophrenia and inform recurrent patients of the latest developments in terms of treatment options.

The conscious limitation of sessions to an average of 8, together with a central focus upon central facts, entails that these groups are also suitable for the severely ill.

The parallel inclusion of relatives in separate groups, which are also temporary and limited to between 6 and 12 evenings, can help less motivated or occupationally busy relatives be won over for regular visits.^{30,46}

For patients suffering from a less severe schizophrenic clinical course, these basic orientation sessions may, together with expedient relapse prevention, be adequate in providing stability.

In the case of more seriously impaired patients, these groups can be successful in motivating and convincing individuals to opt for involvement in long term and more differential therapy.

Chronic patients can, through recurrent integration in this group concept, be sent a sign of hope insofar as they have not been forsaken or abandoned to their fate despite multiple relapses. Patients thus sense that others believe that they are able to recover in the face of repeated relapses.

Standing of Psychoeducation Within a Multimodal Treatment Concept

Psychoeducation is by no means a rival to continuative cognitive behavioral therapy or other forms of psychotherapy in general. On the contrary, psychoeducation is to be seen as a precursor and catalyst for subsequent complementary psychotherapeutic and psychosocial treatment strategies, such that patients and their relatives

are in a position to discover the form of treatment which is optimal for their respective phase of illness.

Viewed in this manner, psychoeducation is ascribed a basal psychotherapeutic function, setting the general course for successful long-term coping in the case of first episode patients and adjusting the course once again for relapsed patients. Through the employment of well-established elements from supportive and cognitive behavioral therapy, it is possible to draw up a pragmatic therapy concept which accommodates the specific needs of the afflicted patients at the same time as incorporating their unquestionably retained resources.⁴⁷⁻⁵¹

On the basis of a successful psychoeducational “compulsory-exercise” program, including sufficient pharmacotherapeutic relapse prevention, numerous continuative treatment methods can be built up in the sense of a “voluntary-exercise,” such as supportive therapy, cognitive behavioral therapy, psychosocial support, etc.

Further scientific investigations should attempt to establish which patients adequately profit from a compulsory-exercise program and which require longer term psychosocial measures, “voluntary exercises.” Limitations of a compulsory-exercise program on account of cognitive impairments must be explored in order to avoid an overstimulation of seriously ill and vulnerable patients.⁵²

Meanwhile, almost all mental and increasingly more somatic or psychosomatic disorders are accompanied by individual psychoeducational concepts. This ensures that the fundamental right of patients to receive a comprehensive explanation of their illness and to be given the chance of an informed involvement in the drafting of their treatment concept is provided for. This is the foundation for achieving optimal collaboration between self-help powers and empowerment on the one hand and offers of professional help on the other hand. A more potent precondition for the effective treatment of schizophrenic disorders is scarcely imaginable.

At the moment, in psychiatric hospitals in Germany, Austria, and Switzerland, psychoeducational groups are provided only for 21% of the patients with a schizophrenic disorder and for only 2% of their relatives.⁵³

In order to promote the implementation of psychoeducation within the German-speaking countries, the “German Society for Psychoeducation” (German: DGPE) was founded in the year 2005.

Acknowledgments

We thank all patients and their relatives, who have participated in our psychoeducational groups and have given us the opportunity to learn from their experiences and to study their empowerment. We also thank our colleagues from the psychiatric hospital “rechts der Isar” for their fantastic work over the last 2 decades and for having helped to implement psychoeducation into standard therapy. We greatly

appreciate the scientific input and advice provided by members of the working group “Psychoeducation of patients with schizophrenia.”

Funding for the research and the Open Access publication charges was provided by Josef Bäuml.

References

- American Psychiatric Association. *Guidelines for Treatment of Schizophrenia*. Washington, DC: American Psychiatric Association; 2004.
- DGPPN. *S-3-Behandlungsleitlinie Schizophrenie*. Darmstadt, Germany: Steinkopff; 2006.
- Dixon L, Adams C, Lucksted A. Update on family psychoeducation for schizophrenia. *Schizophr Bull*. 2000; 26:137–139.
- Pekkalä E, Merinder L. Psychoeducation for schizophrenia. *Cochrane Rev Cochrane Data Base Syst Rev*. [serial online]. 2002;No. CD002831:1–41.
- Zubin J, Spring B. Vulnerability: a new view of schizophrenia. *J Abnorm Psychol*. 1977;86:103–126.
- Falloon IR, Held T, Roncone R, Coverdale JH, Laidlaw TM. Optimal treatment strategies to enhance recovery from schizophrenia. *Aust N Z J Psychiatry*. 1998;32:43–49.
- Möller HJ. Course and long-term treatment of schizophrenic psychoses. *Pharmacopsychiatry*. 2005;37(suppl 2):126–135.
- Knuf A, Seibert U. *Selbstbefähigung fördern*. Bonn, Germany: Psychiatrie-Verlag; 2001.
- Kraemer S. Cognitive behaviour therapy and its differential effects in the treatment of chronic schizophrenic patients. In: Merlow MCG, Perris C, Brenner HD, eds. *Cognitive Therapy with Schizophrenic Patients. The Evolution of a New Treatment Approach*. Göttingen, Germany: Hogrefe & Huber Publishers; 2002:136–166.
- Tarrier N. Cognitive behaviour therapy for schizophrenia—a review of development, evidence and implementation. *Psychother Psychosom*. 2005;74:136–144.
- Klingberg S, Buchkremer G. Cognitive behavioral treatment of schizophrenia—ways towards differential indication. *Fortschr Neurol Psychiatr*. 2001;69(suppl 2):132–137.
- Brenner HD, Pfammatter M. Psychological therapy in schizophrenia: what is the evidence? *Acta Psychiatr Scand*. 2000;102(suppl 407):74–77.
- Yalom ID. *Theorie und Praxis der Gruppenpsychotherapie*. München, Germany: Pfeiffer; 1989.
- Penn DL, Mueser KT, Tarrier N, et al. Supportive therapy for schizophrenia: possible mechanisms and implications for adjunctive psychosocial treatments. *Schizophr Bull*. 2004; 30:101–112.
- Antonovsky A. *Salutogenese. Zur Entmystifizierung der Gesundheit*. Tübingen, Germany: dgvt; 1997.
- Glynn SN, Cohen AN, Dixon LB, Niv N. The potential impact of the recovery movement on family interventions for schizophrenia: opportunities and obstacles. *Schizophr Bull*. In press.
- Angermeyer MC, Matschinger H. Causal beliefs and attitudes to people with schizophrenia. Trend analysis based on data from two population surveys in Germany. *Br J Psychiatry*. 2005;186:331–334.
- Bäuml J. Psychoedukation aus psychiatrisch-psychotherapeutischer Sicht. *Psychiatr Prax*. In press.
- Grawe K, Donati R, Bernauer F. *Psychotherapie im Wandel. Von der Konfession zur Profession*. Göttingen, Germany: Hogrefe; 2004.
- Pitschel-Walz G, Bäuml J. Psychotherapie bei Schizophrenien: Ergebnisse von Meta-Analysen zur Wirksamkeit. *Psychiatr. Prax*. In press.
- Seligman MEP. *Helplessness on Depression, Development and Death*. San Francisco, Calif: Freeman, N.H. & Company; 1975.
- Anderson CM, Gerard E, Hogarty GE, Reiss DJ. Family treatment of adult schizophrenic patients: a psycho-educational approach. *Schizophr Bull*. 1980;6:490–505.
- Goldstein MJ, Rodnick EH, Evans JR, et al. Drug and family therapy in the aftercare of acute schizophrenics. *Arch Gen Psychiatry*. 1978;35:1169–1177.
- Falloon IR, Boyd JL, McGill CW, et al. Family management in the prevention of morbidity of schizophrenia. *Arch Gen Psychiatry*. 1985;42:887–896.
- Leff J, Kuipers L, Berkowitz R, et al. Controlled trial of social intervention in the families of schizophrenic patients: two year follow-up. *Br J Psychiatry*. 1985;146: 594–600.
- Tarrier N, Barrowclough C, Vaughn C, et al. Community management of schizophrenia—a two-year follow-up of a behavioural intervention with families. *Br J Psychiatry*. 1988; 154:625–628.
- Lieberman RP, Mueser KT, Wallace CJ, et al. Training skills in the psychiatrically disabled: learning coping and competence. In: Straube E, Hahlweg K, eds. *Schizophrenia. Concepts, Vulnerability and Models*. Berlin, Germany: Springer-Verlag; 1990:193–216.
- Hogarty GE, Anderson CM, Reiss D, et al. Family psychoeducation, social skills training and maintenance chemotherapy in the aftercare treatment of schizophrenia: II. Two-year effects of a controlled study on relapse and adjustment. *Arch Gen Psychiatry*. 1991;48:340–347.
- Wiedemann G, Klingberg S, Pitschel-Walz G. Psychoedukative Interventionen in der Behandlung von Patienten mit schizophrenen Störungen. *Nervenarzt*. 2003;74:789–808.
- Pitschel-Walz G, Leucht S, Bäuml J, Kissling W, Engel RR. The effect of family interventions on relapse and rehospitalization in schizophrenia—a meta-analysis. *Schizophr Bull*. 2001;27:73–92.
- Pharoah FM, Rathbone J, Mari JJ, Streiner D. Family intervention for schizophrenia. *Cochrane Database Syst Rev*. [serial online]. 2003;4:CD000088.
- Penn DL, Mueser KT. Research update on the psychosocial treatment of schizophrenia. *Am J Psychiatry*. 2004;153:607–617.
- Pilling S, Bebbington P, Kuipers E, et al. Psychological treatment in schizophrenia: I. meta-analysis of family intervention and cognitive behaviour therapy. *Psychol Med*. 2002;32: 763–782.
- Bäuml J, Pitschel-Walz G. *Psychoedukation bei schizophrenen Erkrankungen*. Stuttgart, Germany: Schattauer; 2003.
- Cunningham ODG, Carroll A, Fattah S, Clyde Z, Coffey I, Johnstone EC. A randomized, controlled trial of a brief interventional package for schizophrenic out-patients. *Acta Psychiatr Scand*. 2001;103:362–369.
- Pitschel-Walz G, Bäuml J, Bender W, Engel RR, Wagner M, Kissling W. Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project study. *J Clin Psychiatry*. 2006;67:443–452.

37. Bäuml J, Pitschel-Walz G, Berger H, Gunia H, Heinz A, Juckel G. *Arbeitsbuch PsychoEduktion bei Schizophrenie (APES)*. Stuttgart, Germany: Schattauer; 2005.
38. Cohen S, Gottlieb BH, Underwood LG. Social relationships and health. In: Cohen S, Underwood LG, Gottlieb BH, eds. *Social Support Measurement and Intervention*. New York, NY: Oxford University Press; 2000:3–25.
39. Coursey RD, Farrell EW, Zahniser JH. Consumers' attitudes towards psychotherapy, hospitalization, and aftercare service. *Health Social Work*. 1991;16:155–161.
40. Ostrom TM. The sovereignty of social cognition. In: Wyer RS, Srull TK, eds. *Handbook of Social Cognition*. Vol 1. Hillsdale, NJ: Erlbaum; 1984:1–37.
41. Horvath AO, Luborsky L. The role of the therapeutic alliance in psychotherapy. *J Consult Clin Psychol*. 1991;38:139–149.
42. Gould RA, Mueser KT, Bolton E, Mays V, Goff D. Cognitive therapy for psychoses in schizophrenia: an effect-size analysis. *Schizophr Res*. 2001;48:335–342.
43. McFarlane W. *Multifamily Groups in Treatment of Severe Psychiatric Disorders*. New York: Guilford Press; 2002.
44. Turkington D, Kingdon D, Weiden P. Cognitive behaviour therapy for schizophrenia. *Am J Psychiatry*. 2006;163:356–373.
45. Wolfle M, Onnen V, Vollmer E, Steinert T. Standard treatment of schizophrenia and legality of personal equipment in psychiatric hospitals (German Psych-PV): possibilities and limitations. *Psychiatr Prax*. 1999;26:238–241.
46. Bechdolf A, Kohn D, Knost B, Pukrop R, Klosterkötter J. A randomized comparison of group cognitive-behavioural therapy and group psychoeducation in acute patients with schizophrenia: outcome at 24 months. *Acta Psychiatr Scand*. 2005;112:173–179.
47. Cather C, Penn D, Otto MW, Yovel I, Mueser KT, Goff DC. A pilot study of functional cognitive behavioural therapy (fCBT) for schizophrenia. *Schizophr Res*. 2005;74:201–209.
48. Jones C, Cormac I, Silveira da Mota Neto JI, Campbell C. Cognitive behaviour therapy for schizophrenia. *Cochrane Data Base Syst Rev*. [serial online]. 2004;18:CD000524.
49. Mueser KT, Bond GR. Psychosocial treatment approaches for schizophrenia. *Curr Opin Psychiatry*. 2000;13:27–35.
50. Rector NA, Beck AT. Cognitive behavioural therapy reduces short term rehospitalisation compared with psychoeducation in inpatients with schizophrenia. An empirical review. *J Nerv Ment Dis*. 2001;189:278–287.
51. Hornung P, Feldmann R, Klingberg S, et al. Long-term-effects of a psychoeducational psychotherapeutic intervention for schizophrenic outpatients and their key-persons—results of a five-year follow-up. *Eur Arch Psychiatry Clin Neurosci*. 1999;249:162–167.
52. Pfammatter KAM, Brenner HD. Therapiemanual zur Psychoedukation und Krankheitsbewältigung (PKB). In: Roder V, Zorn P, Andres K, Pfammatter KAM, Brenner HD, eds. *Praxishandbuch zur verhaltenstherapeutischen Behandlung schizophrener Erkrankter*. Bern, Switzerland: Hans Huber; 2002:157–214.
53. Rummel C, Pitschel-Walz G, Bäuml J, Kissling W. Psychoeducation in schizophrenia—results of a survey of all psychiatric institutions in Germany, Austria and Switzerland. *Schizophr Bull*. 2006; doi:10.1093/schbul/sbl006.